Department of Health and Human Services
Division of Health Care Financing & Policy
Meeting for Public Comment on Review
Of Nevada Medicaid Services Manual
October 18, 2005
Minutes

Attendees:

In Carson City, NV:
Charles Duarte, Administrator, DHCFP
John Liveratti, Chief, DHCFP, Compliance
Donald Winne, Sr. DAG
Marti Cote, DHCFP
Nova Peek, DHCFP
Others in attendance shown on attached lists.

In Las Vegas, NV:
Marcie French, DHCFP

The meeting was called to order by John Liveratti, Chief of Compliance at 9:00 a.m. in room 2135 of the Legislative Counsel Bureau at 401 S. Carson Street in Carson City, Nevada. The meeting was aired by videoconference to Las Vegas simultaneously. Those in attendance are on the attached lists from both locations.

I. Discussion and Proposed Adoption of amendments to MSM Chapter 600 – Physician Services.

Marti Cote, SSPS III, Program Services Unit, discussed some proposed changes to MSM Chapter 600, Physician Services. The changes proposed are as follows:

Overall, throughout the Chapter, remove any references to "C" codes. Under 601, Authority, updated and renumbered of the outlining format. Under 603.1.A.2.b.3, Coverage and Limitations, added "unless teaching physician"; Under 603.2.b.1.b, New & Established Recipients, deleted "3 office visits" and added "12 office visits". Under 603.2.b.1.c, New and Established Recipients added "Any exception to the limit requires prior authorization." Under 603.2.A, Authorization Process removed the last line, "please refer to outpatient procedure list and appendix D, because Appendix D no longer exists. Under 603.4, Maternity Care, added "and post partum services." Under 603.4.a.1, Stages of Maternity Care, changed "non-legal, non-residents" to "Ineligible non-citizens". Under 603.7.a, Podiatry, deleted #3, the section which referred to Prior Authorization for Podiatry services because it no longer exists in this chapter. Under 603.10.b.7, deleted the section regarding Clinical Laboratory Services as now in chapter 800. Under section 603.11.f.2.8, Services in Acute Hospital Setting, deleted "90 days" and added, "the Medicare recommended global period". Under 603.11.f.9.b, Critical Care, deleted "99297" as no longer a valid code.

Under Policy #6-01 Colorectal Cancer Screening, deleted prior authorization verbiage-no longer required. Under Policy #6-02 Wound Management, rearranged supply verbiage. Attachment C Emergency Room List, deleted from the chapter because it's in the billing manual.

In addition, upon approval of these changes, a PDR has been written for the high complexity codes that were changed from 3 visits to 12 visits.

Mr. Liveratti asked Ms. Cote when she was anticipating this change to go through. Ms. Cote said they would recycle everything back to the day the policy change goes into effect.

Mr. Duarte asked Ms. Cote if the list of covered emergency ICD-9 codes was being revised. She said yes, the list changes every year when new codes are added, and the revision on the list is in the billing manual, so it's easier to make adjustments.

Mr. Liveratti asked if there were any comments from the audiences in Carson City or Las Vegas, and there were none.

Mr. Liveratti recommended to the Administrator, Chuck Duarte, that this chapter be approved as submitted and Mr. Duarte stated he will accept the changes after one more round of spell check and grammar check.

Mr. Liveratti closed the meeting on MSM Chapter 600 and called on Nova Peek to discuss MSM Chapter 100 changes.

Nova Peek, SSPS III, Provider Support Unit, discussed the proposed changes for the first MTL dated August 2, 2004. The changes proposed are as follows:

Under 103.2, Medicaid Eligibility, added Nevada Checkup program information. Under 103.2A, added Medicaid information for clarification and removed the Nevada Checkup reference because it was added previously. Under 103.4, Payment Eligibility, the title was changed and "Medicaid Services" added. Under 103.4B, Out of State Services, added Section 103.20 due to topic. Under 103.5A.4, Card Information and Use, clarified that eligibility is determined monthly; eligibility should be verified prior to providing services, and 103.5A.9 and 103.5A.10, added clarification regarding EVS and removed sentence indicating plastic card is proof of eligibility, as it is no longer needed-clients cannot be denied service for not supplying the card because they can be verified in EVS.

Mr. Duarte asked if this change is in the provider agreement as well, and Ms. Peek confirmed that it is.

Ms. Peek continued with Section 103.5B, Provider Responsibility, deleted paragraph 8 and renumbered; 103.5C, deleted requirement for client to provide a Medicaid Card.

Mr. Liveratti asked for questions or comments and there were none from Carson City or Las Vegas.

Ms. Peek continued with her 2nd MTL dated November 22, 2004:

Under 103.6 updated language regarding Medicare EOB information in billing manual so that they can use procedure in the billing manual instead of through policy, and updated language to reflect current State Plan requirements regarding HIPP- it's not changed in the Manual, but looks more like the State Plan. Under 103.6A.6, Payment Criteria, changed all HMO references to OHC (other health coverage), all types of services must follow this requirement. Under 103.6A.13 corrected policy intent; providers must pursue all TPL and not just Medicare. Under 103.6B, Provider Responsibility, deleted the requirement to provide card and added EVS/swipe card vendor; changed a bit of TPL language from specialist to unit. 103.6B changed HMO to OHC and added previous paragraph to clarify intent; changed resource to health coverage; deleted requirement of copy of check as not required; 103.6B.4 added language requiring providers bill for co-pay and deductible-in no instance can they bill Medicaid for exceeds client's legal obligation to pay. 103.6B.8 deleted billing information pertaining to pharmacy HMO's as it should be included in pharmacy billing manual; deleted information regarding capitated HMO as it should be in the billing manual. 103.6D, NSWD District Office Responsibility, this is revised and directs providers to contact fiscal agent's TPL unit instead of DHCFP Central Office.

Mr. Duarte wants to make sure Sections 103.6C and 103.6D are brought to the attention of the Welfare unit responsible for Medicaid eligibility and TPL collection.

Mr. Liveratti said he'd like to change the acronym for Welfare from NSWD to DWSS throughout the MSM Chapters 100 and 600 as it is now the Division of Welfare and Support Services and not Nevada State Welfare Division.

Ms. Peek continued with 103.7B, Medicaid Payments: Provider Responsibility- deleted information regarding previous policy through Anthem about additional filing days as already updated in the Billing Manual and also updated obstetrical billing information to reflect correct billing process.

Mr. Liveratti asked if there were any questions and there were none in Carson City or Las Vegas.

Ms. Peek began with 103.8, Related Provider Responsibilities: changed title and amended format; 103.8.3 the information was moved from under 103.8.b. as this was deleted. Under section 103.10, added group enrollment, that groups have ability to bill for Medicaid services and added non-covered services policy.

Mr. Duarte asked if this would be the section applicable to the enrollment of the new Behavioral Health Networks and Ms. Peek responded that no, that information has not yet been determined. The enrollment would go under enrollment and not billing, so it would not be in this chapter.

Ms. Peek continued with Section103.10B, Provider Responsibilities: removed timely filing from Medicaid disclosure policy as redundant; under section 103.11, Provider Enrollment, changed format and updated section to reflect change of duties from DHCFP to fiscal agent and added that the provider must comply with all Federal, State and local statutes, rules and regulations with regards to services being provided. Under 103.11, number 4, providers may request enrollment in the Nevada Medicaid Program by contacting the Provider Enrollment Unit of the fiscal agent. Under 103.11A, Conditions of Enrollment, this was deleted, and most information moved to 103.10 when not redundant, as was 103.11B. 103.12, Provider Participation, removed general conditions of participation from this section and changed section to “Out of State Provider Participation”; amended policy to exempt Out of State providers from the formal enrollment process when providing services on a one-time emergent basis. It allows the provider to use the bill for services-as long as they are a Medicaid provider in their state-without completing a contract.

Mr. Liveratti asked Ms. Peek if this is the CMS recommendation that the states adopt the processes that Hawaii has in place in using Medicaid providers from other states. That process is such that if the providers are already licensed in their own state, they could avoid having to apply for a Medicaid Provider number for our state just by showing proof that they are contracted for their state. This would speed up the process for all out-of-state claims. They would be able to submit their claim with a W-9 and proof of being a Medicaid provider in their home state and as long as they meet the policy guidelines of services Medicaid covers. By doing this they would have a Medicaid billing number for 90 days to allow the claim to pay, and after that 90 days it shuts off.

Mr. Duarte will follow up with Ms. Peek and Mr. Liveratti on whether other states in the region have accepted this type of reciprocity agreement.

Ms. Peek continued with 103.12: Conditions of Participation, added information from previous sections for format changes, added policy requiring providers be responsible for requirements of their provider type. Under 103.12B, Applicant/Provider responsibilities, deleted as the information is redundant and found in a previous section.

Mr. Liveratti asked if there were any other questions or comments on this section and there were none in Carson City or Las Vegas.

Ms. Peek continued with the MTL dated July 28, 2005. She pointed out that on the first page of the actual Policy for Section 103, the "undo" on the numbering didn't come through and the section shows as 103.11B, but should actually read 103.13B. Next, beginning with Section 103.14A.4, Conditions of Provider Disclosure; will add to this section the ability for DHCFP to conduct pre-enrollment audits. In 103.15, Contract Approval, added language to clarify the process for when the approval letter is received and the contract approved.

Mr. Duarte questioned the numbering and he's not sure it's matching the MTL. He suggested cross-referencing the sections on the MTL with the old sections of the draft chapter beginning with 103.15. Ms. Peek said that if it had been "undone" as intended that would have corrected this problem. She will take care of it after this meeting.

Ms. Peek continued with 103.15 (103.13(5)A incorrectly in the draft), the Contract Approval section. In 103.15C, Procedures for Contract Denial, added chapter reference for hearings; under 103.16 (103.14 incorrectly in the draft), Contract Terminations and Renewal, changed contract termination guidelines to match HMO vendors. Under 103.16A, Procedures for Termination, 103.17A, Procedures for Administrative and 103.18C, Termination and Suspension, all sections will add a chapter reference for hearings. For section 103.18D, Reinstatement Rights, (the numbering was different in the previous chapter), added policy for voluntary terminations-when a provider voluntarily terminates, they will be given 120 days from that termination date to request a re-enrollment without going through the enrollment process; under103.20, Medicaid Services, removed and added to section 103.4.

Mr. Liveratti reiterated the numbers need to be corrected and Ms. Peek agreed that all needed to be done is the document be "undone" and that will correct everything.

Mr. Liveratti asked if there were any questions or comments from Carson City and Las Vegas and there were none. He opened discussion on the last MTL of MSM Chapter 100, dated July 28, 2005.

Beginning with Section 104.41A.1, Provider Claim Appeals. In this section the information is being rearranged by topic. Also, removed claim adjustment information and added to Section 103.9, where claim adjustments are discussed; added references to the Hearings section. Section 104.1B, Provider Responsibility, all the information is redundant and repeated in the "Claim Appeals" section, which was renamed. "Fair Hearings" was removed from that section as it now has its own chapter, In Section 105.1, deleted information about the Provider Enrollment Unit doing EVS updates, as that's done by First Health,

and changed the fax number for our area. In Section 105.2, updated chapter titles to match DHCFP. In Section 105.3 amended title to contact information, added TPL unit information for PCG. In Section 105.6, deleted Definition previously found in the chapter 100. In Section 105.8, updated provider types to match current types.

Mr. Liveratti said that in the original 104.1A, Provider Claim Appeals, it used to state an appeal must be received by the fiscal agent within 30 days of the remittance advice; now the language says to contact the fiscal agent for appeals. We've had requests to extend the 30 day timeframe and due to a survey across the States, the average timeframe would be between 90-180 days. Is this something Medicaid can do, or request this through First Health? Ms. Peek says it's a First Health issue; as it a procedure. Mr. Liveratti recommends a 90 day timeframe on appeals, which would match our hearings. The "Appeals" section, 104.1A, of the Manual used to state 30 days, but that was removed and it's only showing in the "Hearings" chapter. There was discussion as to if this falls under Appeals or Hearings sections, and Mr. Liveratti would like to leave the language in about the days, if it's not a billing issue. If it is a billing issue, it's a First Health issue. It was agreed that they would talk to First Health on the appeals process and 30 calendar day requirement.

Mr. Liveratti discussed the section "Claim for Fair Hearings. Researching the CFR's, the only providers that have hearing rights are nursing facilities and hospitals and their requirement is 60 days. We need to change it from 30 days as it's not in compliance and that it is also changing in the Hearings chapter. Mr. Liveratti would like to change it to 90 days and have it the same in all sections, if there are no objections.

Mr. Duarte stated that he isn't sure about revising the period of time to allow providers to appeal claims; this should be only in the billing manual and this should be discussed more and brought back for hearing because the provider is provided appeal rights in the NRS. Mr. Liveratti and Ms. Peek clarified that they are provided hearing rights in the section in question. Because so many hearings result from provider appeals on claims, he'd like to discuss this further, he's not sure we can relegate this to the billing manual. He doesn't mind changing the timeframe to match the Hearings chapter.

Don Winne, Senior DAG, has concern with putting the claim appeals out 90 days, and the hearing appeal out 90 days, because you may be out 180 days before being able to work on the claim. DHCFP may want to see if, for every appeal, we're not doing a hearing-because if that were the case, it may not be a good idea to extend it out. If all the claims are going to Fair Hearings, then DHCFP may be prejudicing itself by expending so much time up front with nothing gained to show for efforts.

Scott Mayne, DCFS, suggested that language be put in as-in the Claim Fair Hearings- "good cause" for a claim appeal. Where you add the date to 60 – 90 days based on the substantiation of "good cause" to give DHCFP and the providers some flexibility.

Mr. Duarte suggested that no decision be made on the Claims Appeals section until it can be reconsidered taking into account Mr. Mayne's and Mr. Winne's comments and also evaluate the longer timeframe. Then we can bring these issues back for another hearing at a later date. Although there are no changes that are material to the language for the Claims Appeals sections, we do have an obligation to change the Claims Fair Hearings dates to what is recommended in the CFR's, however.

Mr. Duarte recommended that we accept the 90 day recommendation in the Claims Hearings section and review any recommendations for change to the Claims Appeal section.

Mr. Liveratti asked for comments from the audience and there were no comments from Carson City or Las Vegas.

Mr. Liveratti recommended all MTL's for MSM Chapter 100 be approved and the only change would be made in 104.1B, in Claim Fair Hearings, second paragraph to read, "This request must be received by Medicaid within 90 calendar days from the date mailed…"

Mr. Duarte accepts those changes and reiterated the chapter numbering needs to be changed to match the MTL dated 7/28/05.

Mr. Liveratti closed the hearing on MSM Chapter 100 and opened the hearing for general public comments.

Scott Mayne, DCFS, wanted clarification regarding the description in MSM Chapter 102.122 for Residential Treatment Center. He wants to make sure that this description allows for Out-of-State RTC's. The language currently says only those RTC's licensed by the State Health Division's Bureau of Licensure and Certification will be reimbursed. He would like to know that all RTC's that are out of state are still able to be reimbursed.

Ms. Peek said that we don't need to change the *definition* of RTC, but can drop the section of the paragraph referring to any requirements to licensure.

Mr. Duarte said that the revisions for MSM Chapter 100 need to be posted and brought to public hearing on November 15, 2005.

Mr. Liveratti said that since MSM Chapter 400 isn't in effect until January of 2006, there is time to match the 2 chapters if we have another public hearing in December 2005.

Mr. Duarte said that in order to align both chapters for implementation in January of 2006, when MSM Chapter 100 is opened again, the revisions on the Claims Appeals section will need to be finalized so they can take those and the revision on the RTC definition and any other changes for MSM Chapter 100 to public hearing.

Mr. Liveratti asked if there were any questions or comments and there were none from Carson City or Las Vegas.

Mr. Liveratti closed the public hearing at 10:00 a.m.